

Exploration into Community Mental Health Teams in Southampton



Contents

Summary2
Community Mental Health Teams2
Background2
Summary of feedback about Southampton CMHTs3
Scope & Limitations4
East Community Mental Health Team Case Study4
Previous Model of Support before April 20247
Current Model of Support April 2024-Jan 20258
Recommendations14
Comments from Hampshire and Isle of Wight Healthcare NHS Foundation Trust14
Conclusion15

Summary

This report reflects changes made within the East Community Mental Health Team (East CMHT) Southampton in response to feedback from their patients and staff and the introduction of a new Focussed Care Pathway Team. The report aims to help patients and members of the public to understand the systems and structures within local mental health services and CMHTs.

Community Mental Health Teams

The Community Mental Health Teams (CMHTs) in Southampton provide community based mental health support to people who may be experiencing ongoing symptoms of depression, anxiety, schizophrenia and mood disorders. They are a team of mental health practitioners including Social Workers, Occupational Therapists, Community Psychiatric Nurses, Psychologists, Psychiatrists, Support Workers, Peer Support Workers, Carers Support Worker and Administration Support.

Hampshire and Isle of Wight Healthcare NHS Foundation Trust describe Community Mental Health Services on their website: "We provide a wide range of community-based mental health services for people who need ongoing support for their mental health issues. Tailored to individuals, we use psychological interventions, group and one-to-one therapy and social and emotional support, as well as medication options". Community Mental Health Services (Adults):: Hampshire and Isle of Wight NHS Foundation Trust

In Southampton (SO14-SO19 postcodes) there are three Community Mental Health Teams - Central (College Keep) and West (Cannon House) and East Community Mental Health Team (ECMHT). All three teams are now part of the Hampshire and Isle of Wight NHS Foundation Trust which formed on the 1st October 2024 (formerly Southern Health Foundation Trust and Solent NHS Trust).

Background

Healthwatch Southampton (HWS) encourages people to share their experiences of health and social care within Southampton. The feedback we receive can be used to build a better picture of Health and Social Care within Southampton – what areas are

doing well and what areas needs improving. We are then able to work with local care providers to advocate for real changes that will improve services locally. The public can leave comments, views and concerns using our Feedback Centre, or contact us by our online contact form, telephone or email.

In 2022 Healthwatch Southampton (HWS) saw a disproportionately high incidence of negative feedback about the Community Mental Health Teams in Southampton (CMHTs). It was also noticeable that there were more reports concerning East Community Health Team. This led to the HWS Team analysing the feedback received from the public and sharing this in order to raise the issue with the CHMTs.

HWS continued to monitor the feedback received about Southampton Community Mental Health Teams and in July 2024 completed another report to collate HWS feedback from November 2022- July 2024.

Summary of feedback about Southampton CMHTs

The overarching themes of the feedback Healthwatch Southampton has received from November 2022 – July 2024 remained similar to the themes that had previously been identified in the HWS report created in October 2022:

- Inadequate or inconsistent support
- Poor communication with staff
- Poor referral process- lack of communication/assessments shared between other services
- Lack of informed and structured support plan
- Lack of frequent reviews/follow up support
- Long waiting times for care coordinator/changes in care coordinators.

The feedback from November 2022-July 2024 also identified some new themes:

- Dissatisfaction with the complaints procedure
- Lack of access/long wait times for psychological therapy
- Access to crisis support
- Lack of understanding of eligibility criteria and not knowing which service can support needs

- People feeling they do not meet any criteria for support (too high needs for one service, but not enough for another)
- Negative engagement with staff (front line, care coordinators & management)
- Clear communication with people and their carers about care plans, reviews, discharge.



Team is having extensive problems because of long waiting list because of lack of psychological staff. This is impacting negatively on patients with acute childhood experiences and multiple traumas.



Scope & Limitations

Healthwatch Southampton acknowledges that the feedback that it received between November 2022 and July 2024 is a small sample of patient experience – a total of 38 stories. We also acknowledge that people often come to us with feedback when they have had a negative experience of the service so we may not see the full picture and be able to represent fully a balanced view of the patient experience.

East Community Mental Health Team Case Study

After sending our collated feedback to the provider of community mental health services, HWS met with the Manager of East Community Mental Health Team and Community Mental Health Lead at HIOW Healthcare Foundation Trust in October 2024 to discuss the issues.

Hampshire and Isle of Wight Healthcare NHS Foundation Trust also receive ongoing feedback from patients and carers about all of their services including Community Mental Health Teams via their Patient Advice and Liaison Service (PALS). The East

Community Mental Health Team had also reviewed some of the feedback they had received and in addition conducted an internal survey with staff and patients and included basic questions about patients' understanding of the service and support. The survey identified the importance of setting expectations with patients at the beginning of their support pathway. Some of the issues identified were:

- Issues with care plans either not in place or not made in partnership with patients
- Issues with care plan reviews
- Low throughput of patients being discharged after successful completion of care plans.
- Long waiting lists for support
- Patients who needed short term and long-term input were grouped together
- Patients with lower level of need would remain on the waiting list or not prioritised
- Patients on waiting lists who didn't know they were still on a waiting list but thought they had been discharged.

The survey results provided both positive and negative feedback and helped to inform changes that were needed. Most of the ideas for the restructuring of the service came from within the team. The Team decided to 'Be Brave' and just implemented the changes and didn't spend too long thinking about it.

These changes included:

- Changes to the waiting list process the initial assessment takes place within a
 few weeks and at that point patients are triaged at a pathway clinic (where
 expectations are set, crisis planning completed and an extended assessment if
 needed, or they will be signposted back to GP/other services).
- Changes to the structure of the staff team the team is now split into a focused care pathway team and the enhanced pathway team.
- Working with stakeholders and partners to ensure improved pathways with referrals and discharges including regular weekly meetings with Primary Care Networks, Child and Adolescent Mental Health Services (CAMHS).
- Resolving staff issues including staff changing roles and improving vacancy rates.
- Introduction of a Carers worker providing support to 30 carers. They offer group support, however, most want one-to-one support. The Staff member works some early mornings or evenings to improve accessibility of the support availability.

Previous Model of Support before April 2024

Prior to April 2024, the East CMHT was an Integrated service with Health & Social Care working together. The team had staff employed by Southampton City Council. These staff roles returned to Adult Social Care Team in April 2024 and health and social care services were separated.

All Mental Health Practitioners within the team supported patients with a varied level of need/support (short-term, long-term, trauma, etc). All staff members were part of the Shared Care Rota – as well as their own caseload of patients, Mental Health Practitioners support a rota to provide additional and broader support to patients with increased need to avoid crisis. The referral to initial assessment process currently meets targets of 28 days, however onward interventions can be lengthy in wait. Contact and progress are then somewhat stilted. Patients waiting may have issues that need immediate support/and/or signposting e.g. accommodation. Care and support were focussed on care plans, but staff were not always writing care plans with patients and not always reviewed when changes occurred. Approximately three years ago ECMHT recruited for a Shared Care Lead, a duty manager and a support worker to focus on duty and Shared Care. This meant that there was now a consistent team in place for providing additional support to people when their needs increase. They had a practitioner led clinic which was mostly used for discharging patients. The practitioner who led the clinic, built links and liaised with the Primary Care Networks. This system had its benefits but also was restrictive with the amount of people who could be within that clinic due to limited resources.

Current Model of Support April 2024-Jan 2025

Referral & Assessment Process

The East Community Mental Health Team accepts referrals from Primary Care (including GP, Nurses, Mental Health Practitioners etc) and other local statutory and voluntary sector organisation. If an assessment has been completed by a mental health practitioner at primary care or voluntary sector level, EMHCT will use this assessment received rather than repeat the process but will add on any additional information or issues identified through discussion or care planning.

Signposting to any other services that are needed can now happen at an earlier stage, as part of the assessment or care plan. Patients and mental health practitioners can identify what ECMHT can support with (self-identified support), what the patient can you do for themselves, and what other services can do and if the patient needs to be referred or signposted to for additional support.

If referrals are identified as inappropriate at the referral screening meeting, they will be referred to other services e.g. Steps to Wellbeing/GP Services. This referral screening meeting happens three times a week. The referrer is informed of the outcome and any recommendations. The team leader meets weekly with the local Primary Care Network and Steps to Wellbeing. This has enabled them to ensure they are clear on decisions that are made about eligibility and appropriate support for each patient. Eligibility for support with the East Community Mental Health Team can be complex but in broad terms the patient will be experiencing severe and enduring mental health problems that has an impact on their ability to function. If the patient is identified as eligible for support with the East Community Mental Health Team, then they will be allocated to either the Focussed Care Pathway Team or the Enhanced Care Pathway Team.

East Community Mental Health Team Support Structure

Referral





Focussed Care Pathway

A shorter term pathway of care focussed on relevant and achievable goals towards recovery. Patient and mental health practitioner develop a care plan.

Enhanced Care Pathway

A pathway of care that delivers enhanced level of support for patients. Patient and mental health practitioner develop a care plan.





Care Pathway Clinic

This clinic provides up to four sessions of support at the start of a patients journey where patient and mental health practitioner and will ensure assessment, risk assessment and crisis plan.

Shared Care Team

The Shared Care Team provide additional support to patients in either the focussed or enhanced care pathway when a need has been identified.

Care Pathway Clinic

The Care Pathway Clinic started in June 2024 and now has a dedicated team. The Clinic can offer patients up to four appointments soon after referral stage. After the Care Pathway Clinic, the patient would then follow either the Focussed or Enhanced Care Pathway depending on need.

At these appointments the patient and mental health practitioner will complete an assessment, crisis plan, risk assessment if needed (if not in place at referral stage). The Care Pathway Clinic is an opportunity to check that the patient is ready and able to engage with support and is used to confirm the patient is moved onto the correct pathway within the Community Mental Health Team (Enhanced or Focussed Care).

Focussed Care Pathway

The Focussed Care Pathway was introduced in April 2024. It provides Focussed short-term support. Soon after referral a patient on this pathway will be allocated a mental health practitioner who supports the patient from the start of their support until their discharge.

The patient creates a plan at the start of journey with a mental health practitioner to identify relevant and achievable goals using a person-centred approach. They use a patient rated outcome measure to support care planning. The outcome measure called Dialog + guides a person-centred conversation focusing on an aspects of someone life to help identify current needs and set goals. This measure is used throughout the person's contact with the team and will be repeated at relevant intervals to establish if the input/interventions provided are making a difference for that person. Example: if they have an issue with accommodation that impacts their mental health. The patients care plan, and the allocated mental health practitioner works towards discharge providing continuity and the patients work with the same member of staff throughout their journey.

The length of time patients spend with the Focussed Care Pathway (FCP) Team will vary but the important point is that it is goal orientated rather than a set time or number of sessions. The number of support sessions are agreed between the mental health practitioner and patient. When the identified focused work is completed, the patient will move on in their care pathway to either discharge back to primary care or a different identified part of the service e.g. Psychology. The Focussed Care Pathway team have regular reviews (approx. 3 monthly). Throughput is essential within the FCP

so they can efficiently take new cases, however, patients care and achievement of focused goals is the priority.

Expectations of patients are made clear from the beginning of the journey (and are included in a leaflet):

- > A commitment to recovery journey
- > To attend appointments
- > To engage with tasks agreed in the care plan
- To complete outcome monitoring forms.

Expectations of the support that the ECMHT mental health practitioners will offer is also made clear (and are included in a leaflet):

- A personalised care plan focussed on recovery
- Working together towards recovery
- Crisis plan development
- Signposting to other organisations as needed
- Access to Employment support, Peer Support, Psychology (if needed), Duty Team, Carers Support and the Recovery College (an educational environment offering courses to support individuals in their recovery)
- Support to transition back to primary care (GP) on discharge.

The focussed care pathway team has a support buddy system in place to ensure that if a mental health practitioner is absent then there is consistent support in place from a familiar face. Outcome measurement tools are used at the start and end of the patient journey to assist in measure changes in mental health and the impact of the support. The tools used are Dialog+ - DIALOG+ | East London NHS Foundation Trust From April 2024-Jan 2025 the focussed care pathway has had 108 new referrals, 90 discharges and still holds a current caseload of 89. They now have 3.3 full time equivalent staff (although there have been some fluctuations in staffing levels over the last 10 months).

Patients may be referred for psychological interventions within the team in addition to the initial support offered. The Mental Health Practitioners have regular clinical supervision with a psychologist, so they can access advice and support on their approaches to supporting patients. Team leaders will hold cases (currently 14) – these patients have completed a program of support on the focussed care pathway and have been referred for psychological intervention and are on the waiting list. There is a long waiting list for psychological intervention which varies according which support

the patient is waiting for (between 2 month and a year). The team leader will check in with people who are on the waiting list intermittently.

If someone who is known to the service is referred back, there is minimal waiting, and they are seen quickly and offered a review appointment rather than a new assessment.

Enhanced Care Pathway Team

The Enhanced Care Pathway delivers an enhanced level of support for patients. Patient and mental health practitioner develop a care plan that support the needs identified. The support may involve a variety of different agencies, and the mental health practitioner will coordinate all the support needed from the start of the pathway until discharge.

Shared Care Team

The Shared Care and Duty Team provide additional support to patients when a need has been identified. They work alongside the allocated care coordinated to support identified goals as needed. Other team members do occasionally cover the rota if needed and they are skilled and trained in doing so. A Shared Care plan is created for the patient at the point of needing the increased support and this will be the plan that the Shared Care team work to. The care-coordinator continues to oversee patient's care when they need additional support from the shared care team and has an overview of the support provided by the shared care team. If the shared care is needed for more than two weeks, then this would be reviewed at the multi-disciplinary team meeting.

Impact on Staff Team

The East Community Mental Health Team is a team of mental health practitioners including Social Workers, Occupational Therapists Community Psychiatric Nurses, Psychologists, Psychiatrists, Support Workers, Peer Support Workers, Carers Support Worker and their Administration Support.

Staff Structure

- 1. Shared Care Team
- 2. Focussed Care Pathway Team
- 3. Care Pathway Clinic Team
- 4. Enhanced Care Pathway Team

Staff and managers agreed that it would be good to separate the tasks out so all staff have clear roles. Some staff were resistant to change initially but reportedly now see the benefits. The review and changes of the staff structure gave staff more of a choice to focus on the roles that best suit their skills and interests.

The introduction of the dedicated shared care team in 2021 was a positive for staff as well as patients. It meant that staff no longer had to go on shared care rota and patients received more consistent crisis support. The staff in the Shared Care Team then became the experts at crisis work and were consequently more efficient. Each team meets for peer supervision and support each other with their work. Patients are now allocated a team of practitioners that are passionate about this approach. Practitioners are clearer about the support they are offering. Smaller teams mean better working relationships, quicker meetings and increased teamwork etc. There is now a lower level of vacancies within the staff team with people usually moving on from the team to other development opportunities rather than leaving because they are not happy in their role. Since the formation of HIOW Healthcare NHS Foundation Trust (joining 4 organisations) on 1st October 2024 there are more training opportunities for staff.

Continuing Challenges

The Community Mental Health Teams (CMHTs) in Southampton operate independently but meet weekly with other teams to ensure that clinical governance structure is maintained and aligns across the wider Trust. This continues to be actively supported but given the geographical / and population differences there are expected to be some variance in provision. This has enabled the East Community Mental Health Team to make some internal changes to its staff structure to enable the structure of support for the local populations needs.

Patients may be feeling unsettled and nervous on discharge because of the transition of support from the East Community Mental Health Team to Primary Care and so this may affect the outcome measurement process. Discharge should not come as a surprise to patients as this should be the ultimate goal. Dialog + is used to identify goals that the patient wishes to achieve and who is best to support the patient in achieving the goal. A dialog + plan will also be agreed with the patient and shared with Primary Care if appropriate.

The East Community Mental Health Team collects qualitative patient feedback after support and on discharge. What went well? What did not go well? They are planning to evaluate the results from this process and present them to the team in April 2025.

Recommendations

During the process of evaluating the changes at the East Community Mental Health Team, Healthwatch Southampton has identified the following recommendations for further improvement and learning for Community Mental Health Teams in Southampton:

- An increase in shared learning opportunities to celebrate examples of good practice for staff across Southampton Community Mental Health Teams and the wider region of Hampshire and the Isle of Wight.
- The Focussed Care Pathway and Shared Care approach to be shared locally and nationally as a model of good practice.
- East Community Mental Health Team to continue to review the Focussed Care
 Pathway and the Shared Care Team as a model of good practice and will use
 staff and patient surveys to gain ongoing feedback from both staff and patients.
- Hampshire and the Isle of Wight Healthcare NHS Foundation Trust to review provision of trauma therapy available in Southampton in order to reduce the waiting times.
- East Community Mental Health Team and the Hampshire & Isle of Wight Healthcare NHS Foundation Trust to review the Enhanced Care Pathway waiting list and support provision.
- Healthwatch Southampton to continue to capture patient feedback for Community Mental Health Teams in Southampton.
- East Community Mental Health Team to improve communication methods with patients and the general public about the service, support, pathways, eligibility and the patient journey.

Comments from Hampshire and Isle of Wight Healthcare NHS

Foundation Trust

Since the formation of the Hampshire and Isle of Wight Healthcare NHS Foundation Trust, our local services have evolved into the Southampton and Southwest Division. This integration has brought about a number of positive changes to our meeting structures, opening new opportunities for shared learning and collaboration. In Southampton, we are proud to have a well-established Clinical Leadership Network, a dynamic forum that brings together all community service managers and leaders. Meeting twice monthly, this network fosters a culture of continuous learning, reflective practice, and quality improvement. It also serves as a valuable space for collaborative problem-solving and strengthening integrated working across the care pathway. This year, our divisional business plan is centred on two key priorities. First, we are committed to enhancing our trauma pathway. A recent Trust-wide workshop attended by individuals with lived experience, carers, system partners, and staff, marked the beginning of this important, co-produced initiative, which will be developed further within each division.

Our second focus is on improving the flow through our caseloads and embedding the assertive outreach model consistently across all teams. These efforts aim to ensure more responsive, person-centred care and better outcomes for the people we support.

Conclusion

Healthwatch Southampton would like to thank staff from Hampshire and Isle of Wight Healthcare NHS Foundation Trust who gave up their time to help us to understand more about their service and about the changes that have been made. We hope that this report will help patients, families and professionals to understand more about the structure of the East Community Mental Health Team and the pathways of support available. We look forward to working closely with them in the future and hear more from patients of all Southampton Community Mental Health Teams about their experiences of support.

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